

1931
CERTIFICATE OF DEATH

1931

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Date of death: _____
6. Place of death: _____
7. Cause of death: _____
8. Signature of physician: _____
9. Signature of registrar: _____
10. Signature of informant: _____

11. Name of informant: _____
12. Address of informant: _____
13. City and State: _____
14. Date of filing: _____
15. Registrar's Office: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1292

01289

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL <small>or give nearest town</small>) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>Few Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> <u>20-40-2</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deers Head Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ernestine</u> Middle <u>Norma</u> Last <u>Baker</u>				4. DATE OF DEATH Month <u>1</u> Day <u>5</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 21, 1935</u>		9. AGE (In years last birthday) <u>24</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>Talbot Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Roberts</u>				14. MOTHER'S MAIDEN NAME <u>Wendy Brummell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Gustina Roberts</u> Address <u>Trappe, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> <u>825X</u> DUE TO <u>Phlebotrombosis extremities</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u>Paralysis transection of C4 T4</u> DUE TO <u> </u> cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>23 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger auto accident -</u>					
20c. TIME OF INJURY Hour <u>11:55</u> a.m. <u>12:13</u> p.m. Month, Day, Year <u>12 13 1959</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u>Easton</u>	20f. (City or town) <u>Easton</u>	(County) <u>Talbot</u>	(State) <u>Md</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1-6-60</u>			
EXAMINER'S NAME (Type) <u>Earl L. Royer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/9/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Trappe Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Trappe, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Hanna</u>				24. REC'D BY REGISTRAR DATE <u>JAN 13 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		SEX Male	
AGE 45		DATE OF BIRTH 10-15-1900	
OCCUPATION Farmer		PLACE OF BIRTH Baltimore, Md.	
MARITAL STATUS Married		DATE OF MARRIAGE 1925	
PLACE OF DEATH Home		DATE OF DEATH 11-10-1945	
TIME OF DEATH 10:00 AM		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		SIGNATURE OF EXAMINER <i>[Signature]</i>	
SIGNATURE OF WITNESS <i>[Signature]</i>		SIGNATURE OF WITNESS <i>[Signature]</i>	

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy thereof to be sent to the local health officer of the city or county in which the death occurred.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01290

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 683 Fitzwater Street				d. STREET ADDRESS 683 Fitzwater Street			
3. NAME OF DECEASED (Type or print) First James Middle T. Last Collins				4. DATE OF DEATH Month January Day 3 Year 1960			
5. SEX male		6. COLOR OR RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 10, 1865	
9. AGE (In years lost birthday) 94 yrs.		IF UNDER 1 YEAR Months 94 Days 94 Hours 94 Min. 94		IF UNDER 24 HRS. Months 94 Days 94 Hours 94 Min. 94			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer				10b. KIND OF BUSINESS OR INDUSTRY farmer		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Collins				14. MOTHER'S MAIDEN NAME Jane Martin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. no			
17. INFORMANT George Collins, 408 Stewart Place				Address Salisbury Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 782.4 DUE TO Myocardial Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Myocardial Heart Failure DUE TO (c) Myocardial Heart Failure							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Nov 15 , 19 59 , to Jan 3 , 19 60 that I last saw the deceased alive on December 23 , 19 59 , and that death occurred at 5 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Carrie Hearn				DATE SIGNED 1/3/60			
PHYSICIAN'S NAME (Type) Carrie Hearn MD				ADDRESS (Street, city or town, state) 226 N. Wisconsin St Salisbury Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1/5/ 1960		22c. NAME OF CEMETERY OR CREMATORY church cemetery		22d. LOCATION (City, town, or county) (State) Snow Hill Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Clinton F. Stewart				ADDRESS Salisbury Md			
24a. REC'D BY REGISTRAR JAN 7 '60				24b. REGISTRAR'S SIGNATURE Clinton S. Kline			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

ILLINOIS STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

1294 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 1590 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS Royal Oak 20X-2			
3. NAME OF DECEASED (Type or print) First Emma Middle Cook Last Cook				4. DATE OF DEATH Month Jan. Day 13 Year 19 60			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/28/1868	
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months 91 Days 91 Hours 91 Min.		IF UNDER 24 HRS. Months 91 Days 91 Hours 91 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME James Green				14. MOTHER'S MAIDEN NAME Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.				16. SOCIAL SECURITY NO. Unk.			
17. INFORMANT Deer's Head State Hospital Records							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic congestion of lung 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Arteriosclerosis, general							INTERVAL BETWEEN ONSET AND DEATH 5 days ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pyelonephritis, chronic							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Royal Oak	
20f. (City or town) Royal Oak				(County) (State)			
21. I certify that I attended the deceased from Sept. 6 , 19 55 , to Jan. 13 , 19 60 , that I last saw the deceased alive on January 13 , 19 60 , and that death occurred at 10:45pM , from the causes and on the date stated above.							
ACTUAL SIGNATURE V. Juerman				ADDRESS (Street, city or town, state) Deer's Head State Hospital 1/14/60			
PHYSICIAN'S NAME (Type) V. Juerman, M. D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) 1/18/60		22b. DATE THEREOF 1/18/60		22c. NAME OF CEMETERY OR CREMATORY Royal Oak Cemetery		22d. LOCATION (City, town, or county) (State) Royal Oak Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Shiel Boston, Md.				24a. REC'D BY REGISTRAR JAN 28 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hana	

STATE OF TEXAS
COUNTY OF DALLAS

No. 100

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1295 CERTIFICATE OF DEATH

Reg. Dist. No. 01292

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cooper</u>		4. DATE OF DEATH Month Day Year <u>JANUARY 31, 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN-31-1960</u>
9. AGE (In years last birthday) <u>6</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Russell Carroll Cooper</u>		14. MOTHER'S MAIDEN NAME <u>Phyllis Amelia Marshall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Informant</u> Address <u>Hospital Records</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity - Birth Wt. - 2nd 7oz</u> DUE TO (c) <u>Cerebral Anoxia</u>		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Atelectasis - Fetal Anoxia due to Placental Previa</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>1/31</u> , 1960, to <u>1/31</u> , 1960, that I last saw the deceased alive on <u>1/31</u> , 1960, and that death occurred at <u>2:45</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Salisbury Md</u>	DATE SIGNED <u>1/31/60</u>
ACTUAL SIGNATURE <u>William C. Morgan</u>			
PHYSICIAN'S NAME (Type) <u>William C. Morgan</u>			

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/1/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Shad Point Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Shad Point, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. J. Messing, Biville, Md</u>		24a. REC'D BY REGISTRAR <u>FEB 2 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1/15/11

1296 CERTIFICATE OF DEATH

Reg. Dist. No.

01293

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury 12</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ervin</u> <u>CORNISH</u>		4. DATE OF DEATH Month Day Year <u>JANUARY 27 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/20/1894</u>
9. AGE (In years last birthday) <u>65</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>	
13. FATHER'S NAME <u>Daniel Cornish</u>		14. MOTHER'S MAIDEN NAME <u>Liza Byrd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Daniel Cornish Jr. Eden Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA</u> <u>150X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>METASTATIC CARCINOMA - GENERALIZED</u> DUE TO (c) <u>CARCINOMA ESOPHAGUS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u> <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>150X</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>26 JAN</u> , 19 <u>60</u> , to <u>27 JAN</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>JAN 27</u> , 19 <u>60</u> , and that death occurred at <u>1:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. Gray Kent MD</u>		ADDRESS (Street, city or town, state) <u>H. GRAY REEVES MD</u> <u>Indirect center, Salisbury, Md</u>	
PHYSICIAN'S NAME (Type) <u>William H. James Jr. Princess Anne, Md</u>		DATE <u>FEB 1 '60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/31/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion</u>	22d. LOCATION (City, town, or county) (State) <u>Polk Road, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. James Jr. Princess Anne, Md</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	

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TO HOSPITAL OR FUNERAL HOME: This certificate must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate must be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

STATE OF DEATH

WEST VIRGINIA DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1908

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1297 CERTIFICATE OF DEATH

01294

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City,</u> <u>23X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>		d. STREET ADDRESS <u>R.F.D. # 1 Box 208</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby Boy</u> <u>COTTMAN</u>		4. DATE OF DEATH Month Day Year <u>JANUARY 8,</u> <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JANUARY 8, 1960</u>
9. AGE (In years last birthday) <u>2</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Collier</u>	
14. MOTHER'S MAIDEN NAME <u>Esther Cottman</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service) <u>-</u>	
16. SOCIAL SECURITY NO. <u>-</u>		INFORMANT Address <u>Jessie M. Cottman, Pocomoke City, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity (Birth wt 540 gms)</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January 8, 1960</u> to <u>18 January, 1960</u> , that I last saw the deceased alive on <u>January 8, 1960</u> , and that death occurred at <u>12</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alfred C. Kolls</u> M.D.		ADDRESS (Street, city or town, state) <u>Medical Center</u> DATE SIGNED <u>1/8/60</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/8/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Tindley Chapel, Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton</u> ADDRESS <u>New Church, Va.</u>		24a. REC'D BY REGISTRAR <u>JAN 13 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2082182XVO

1 1298 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01295

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 76 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS 19X-2			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Della Middle Dashiell Last Dashiell				4. DATE OF DEATH Month Jan. Day 12 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC 11-1876	
9. AGE (In years lost birthday) 83 1/2 yrs.		IF UNDER 1 YEAR Months 12 Days 12 Hours 12 Min.		IF UNDER 24 HRS. Months 12 Days 12 Hours 12 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Levin Collier				14. MOTHER'S MAIDEN NAME Elizabeth Collier			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ?				16. SOCIAL SECURITY NO. 217-01-5556 B			
17. INFORMANT Deer's Head Hospital Records							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca. of pancreas with obstructive biliary cirrhosis 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 157X DUE TO (c) 157X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 157X INTERVAL BETWEEN ONSET AND DEATH 5 mon.							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from October 28, 19 59 , to January 12, 19 60 , that I last saw the deceased alive on January 12, 19 60 , and that death occurred at 3:30 PM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 1/12/60							
ACTUAL SIGNATURE Mal duc M.D. Deer's Head State Hospital							
PHYSICIAN'S NAME (Type) L. V. Maldve, M. D. Salisbury, Maryland 1/12/60							
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried							
22b. DATE THEREOF JAN 15-1960							
22c. NAME OF CEMETERY OR CREMATORY St. John's Methodist							
22d. LOCATION (City, town, or county) (State) Deer's Head Md							
23. FUNERAL DIRECTOR'S SIGNATURE L. S. Webster ADDRESS Deer's Head							
24a. REC'D BY REGISTRAR JAN 21 '60							
24b. REGISTRAR'S SIGNATURE Arthur S. Kline							

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1298

CERTIFICATE OF DEATH

Decedent

Age

Sex

Color

Married

Single

Widow

Place of birth

Place of death

1871-1872

1873-1874

1875-1876

1877-1878

1879-1880

1881-1882

1883-1884

1885-1886

1887-1888

1889-1890

1891-1892

1893-1894

1895-1896

1897-1898

1899-1900

1901-1902

1903-1904

1905-1906

Attest: *[Signature]*
Notary Public for the State of New York
My Commission Expires *[Date]*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

BALTIMORE, 18										01296	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 12 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cor.N.Div.St & Main (Hearn Bldg.) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS Hearn Bldg.(Apt.)						
3. NAME OF DECEASED (Type or print) First DOMENICO Middle DE LUCA Last DE LUCA 4. DATE OF DEATH Month JAN. Day 12th Year 19 60					5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Nov.26,1910 9. AGE (In years last birthday) 49 yrs. IF UNDER 1 YEAR 1 Months 1 Days 6 Hours Min. IF UNDER 24 HRS.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Maker-Employee 10b. KIND OF BUSINESS OR INDUSTRY Shoe Repair 11. BIRTHPLACE (State or foreign country) Rome-Italy 12. CITIZEN OF WHAT COUNTRY? U S A					13. FATHER'S NAME Nicola DeLuca 14. MOTHER'S MAIDEN NAME Marie D'annibale						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 420.1 17. INFORMANT Mrs. Mary J. DeLuca (Wife) Address Nazareth, Pa. 18. Ziegler Ave.					18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan.15,1960 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery-R.D.# 22d. LOCATION (City, town, or county) (State) Greensboro, Maryland					23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND 24a. REC'D BY REGISTRAR JAN 15 '60 24b. REGISTRAR'S SIGNATURE Arthur L. Hearn						

1300

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1005 W. Isabella St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LAURA Middle E Last DOVE		4. DATE OF DEATH Month JAN. Day 19th Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 6, 1868
9. AGE (In years last birthday) 92 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Siloam, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Townsend		14. MOTHER'S MAIDEN NAME Elizabeth V. Malone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mr. Sewell H. Dove (Son) Mt. Hermon Rd. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Cardiac Failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH 1 wk	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/1 , 19 60 , to death , 19 60 , that I last saw the deceased alive on 1/15 , 19 60 , and that death occurred at 5:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Jan. 19 / 1960			
ACTUAL SIGNATURE Ernest M. Larmore M.D.		PHYSICIAN'S NAME (Type) Dr. Ernest M. Larmore Delmar, Delaware	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 21, 1960	22c. NAME OF CEMETERY OR CREMATORY Siloam Cemetery	22d. LOCATION (City, town, or county) (State) Siloam, Maryland
23. FUNERAL BURIAL'S SIGNATURE HOLLOWAY & COMPANY SALISBURY, MARYLAND		24a. REC'D BY REGISTRAR JAN 21 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. K...			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1300
CERTIFICATE OF DEATH

10-11-1918

10-11-1918

10-11-1918

10-11-1918

10-11-1918

10-11-1918

10-11-1918

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10-11-1918

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G254 1-18-60 et

01298

1301

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN lb 22 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Emory Middle Joshua Last Ellis				4. DATE OF DEATH Month January Day 5 Year 19 60			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/31/? Approx.	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min. 70	IF UNDER 24 HRS. Months 70 Days 70 Hours 70 Min. 70	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Ellis				14. MOTHER'S MAIDEN NAME Annie Jowns			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None				16. SOCIAL SECURITY NO. None			
17. INFORMANT Deer's Head Hospital Records							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Glomerulonephritis DUE TO (c) Carcinoma of prostate gland							INTERVAL BETWEEN ONSET AND DEATH ? ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 14, 1959 , to January 5, 1960 , that I last saw the deceased alive on January 5, 1960 , and that death occurred at 5:40 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 1/6/60							
ACTUAL SIGNATURE V. Juerman		M.D. Deer's Head State Hospital					
PHYSICIAN'S NAME (Type) V. Juerman, M. D.		Salisbury, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-10-60		22c. NAME OF CEMETERY OR CREMATORY Green Acres Cem		22d. LOCATION (City, town, or county) (State) Salisbury Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Decker McEld				ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 14 '60	
						24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1302 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>705 Parkway Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Laurena</u> Middle <u>Evans</u> Last <u>Evans</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>24</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 18, 1877</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Charles W. Goldsborough</u>				14. MOTHER'S MAIDEN NAME <u>Nancy M. Nelson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unk</u>				16. SOCIAL SECURITY NO. <u>unk</u>		INFORMANT <u>Hospital Records</u> Address <u>Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis of super. mesenteric artery</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis general</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
				20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that I attended the deceased from <u>Sept. 2, 1959</u> to <u>Jan 24, 1960</u> , that I last saw the deceased alive on <u>Jan 24, 1960</u> , and that death occurred at <u>9:00A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>V. Juerman</u>				ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u> DATE SIGNED <u>Jan. 24, 1960</u>			
PHYSICIAN'S NAME (Type) <u>V. Juerman, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>134312</u>		22b. DATE THEREOF <u>JAN 26 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NELSON'S CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>CRISFIELD</u> <u>MA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Webster</u>				ADDRESS <u>CRISFIELD</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 29 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
1912

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John J. Smith		Male		45		Jan. 1, 1867		New York City		New York City		Heart Disease		New York City		10:30 P.M.		J. J. Smith		J. J. Smith	
Occupation		Marital Status		Color		Religion		Education		Previous Illnesses		Manner of Death		Burial Place		Burial Date		Burial Time		Burial Signature	
Clerk		Married		White		Roman Catholic		High School		None		Natural		Catholic Cemetery		Jan. 1, 1912		10:30 P.M.		J. J. Smith	

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/58

1303 CENTRAL DE DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG254 1-18-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

01301

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>082</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SHARPTOWN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>			d. STREET ADDRESS <u>RAILWAY CEMETERY ST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>GERONA MORRIS FLETCHER</u>			4. DATE OF DEATH Month <u>JANUARY</u> Day <u>7</u> Year <u>1960</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 19, 1894</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED SCAMTRASS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>LAUREL, DELAWARE</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>			13. FATHER'S NAME <u>JAMES MORRIS</u>		
14. MOTHER'S MAIDEN NAME <u>ELLEN DICKERSON</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>216-01-6539</u>			INFORMANT Address <u>HOMER FLETCHER, SHARPTOWN, MD</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>1-6</u> , 19 <u>60</u> , to <u>1-7</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-7</u> , 19 <u>60</u> , and that death occurred at <u>12:00 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>W. R. Ellis</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>1-7-60</u>	
PHYSICIAN'S NAME (Type) <u>W. R. ELLIS</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN 10, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FIREMEN'S</u>	
22d. LOCATION (City, town, or county) (State) <u>SHARPTOWN, MD</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul J. Smith</u> ADDRESS <u>SHARPTOWN, MD</u>			
24a. REC'D BY REGISTRAR DATE <u>JAN 12 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01302

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> 1305 MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u> d. STREET ADDRESS <u>Route # 1 Box 81</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jacob Gaines</u> First Middle Last		4. DATE OF DEATH Month Day Year <u>1- 31- 60</u> 19	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Month Day Year <u>78</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry D. Gaines</u>		14. MOTHER'S MAIDEN NAME <u>Melinda Watson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-08-1166</u>	
17. INFORMANT <u>Modelle Gaines</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sub-dural hemorrhage</u> 824 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from truck and was backed over.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>6 A.M. 12-16-60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>Princess Anne</u> (County) <u>Somerset</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		DATE SIGNED <u>2-2-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-5-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chance Cem</u>		22d. LOCATION (City, town, or county) <u>Chancock</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker McWish</u>		ADDRESS 	
24a. REC'D BY REGISTRAR <u>9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. King</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is anticipated, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]	
4. OCCUPATION [Faint text]		5. MARITAL STATUS [Faint text]		6. PLACE OF BIRTH [Faint text]	
7. DATE OF DEATH [Faint text]		8. TIME OF DEATH [Faint text]		9. PLACE OF DEATH [Faint text]	
10. CAUSE OF DEATH [Faint text]		11. MANNER OF DEATH [Faint text]		12. SIGNATURE OF EXAMINER [Faint text]	
13. SIGNATURE OF WITNESS [Faint text]		14. SIGNATURE OF DECEASED [Faint text]		15. SIGNATURE OF NEXT OF KIN [Faint text]	
16. SIGNATURE OF CLERK [Faint text]		17. SIGNATURE OF JURY [Faint text]		18. SIGNATURE OF JUDGE [Faint text]	
19. SIGNATURE OF PROSECUTOR [Faint text]		20. SIGNATURE OF DEFENSE [Faint text]		21. SIGNATURE OF JURY [Faint text]	
22. SIGNATURE OF JUDGE [Faint text]		23. SIGNATURE OF PROSECUTOR [Faint text]		24. SIGNATURE OF DEFENSE [Faint text]	
25. SIGNATURE OF JURY [Faint text]		26. SIGNATURE OF JUDGE [Faint text]		27. SIGNATURE OF PROSECUTOR [Faint text]	
28. SIGNATURE OF DEFENSE [Faint text]		29. SIGNATURE OF JURY [Faint text]		30. SIGNATURE OF JUDGE [Faint text]	
31. SIGNATURE OF PROSECUTOR [Faint text]		32. SIGNATURE OF DEFENSE [Faint text]		33. SIGNATURE OF JURY [Faint text]	
34. SIGNATURE OF JUDGE [Faint text]		35. SIGNATURE OF PROSECUTOR [Faint text]		36. SIGNATURE OF DEFENSE [Faint text]	
37. SIGNATURE OF JURY [Faint text]		38. SIGNATURE OF JUDGE [Faint text]		39. SIGNATURE OF PROSECUTOR [Faint text]	
40. SIGNATURE OF DEFENSE [Faint text]		41. SIGNATURE OF JURY [Faint text]		42. SIGNATURE OF JUDGE [Faint text]	
43. SIGNATURE OF PROSECUTOR [Faint text]		44. SIGNATURE OF DEFENSE [Faint text]		45. SIGNATURE OF JURY [Faint text]	
46. SIGNATURE OF JUDGE [Faint text]		47. SIGNATURE OF PROSECUTOR [Faint text]		48. SIGNATURE OF DEFENSE [Faint text]	
49. SIGNATURE OF JURY [Faint text]		50. SIGNATURE OF JUDGE [Faint text]		51. SIGNATURE OF PROSECUTOR [Faint text]	
52. SIGNATURE OF DEFENSE [Faint text]		53. SIGNATURE OF JURY [Faint text]		54. SIGNATURE OF JUDGE [Faint text]	
55. SIGNATURE OF PROSECUTOR [Faint text]		56. SIGNATURE OF DEFENSE [Faint text]		57. SIGNATURE OF JURY [Faint text]	
58. SIGNATURE OF JUDGE [Faint text]		59. SIGNATURE OF PROSECUTOR [Faint text]		60. SIGNATURE OF DEFENSE [Faint text]	
61. SIGNATURE OF JURY [Faint text]		62. SIGNATURE OF JUDGE [Faint text]		63. SIGNATURE OF PROSECUTOR [Faint text]	
64. SIGNATURE OF DEFENSE [Faint text]		65. SIGNATURE OF JURY [Faint text]		66. SIGNATURE OF JUDGE [Faint text]	
67. SIGNATURE OF PROSECUTOR [Faint text]		68. SIGNATURE OF DEFENSE [Faint text]		69. SIGNATURE OF JURY [Faint text]	
70. SIGNATURE OF JUDGE [Faint text]		71. SIGNATURE OF PROSECUTOR [Faint text]		72. SIGNATURE OF DEFENSE [Faint text]	
73. SIGNATURE OF JURY [Faint text]		74. SIGNATURE OF JUDGE [Faint text]		75. SIGNATURE OF PROSECUTOR [Faint text]	
76. SIGNATURE OF DEFENSE [Faint text]		77. SIGNATURE OF JURY [Faint text]		78. SIGNATURE OF JUDGE [Faint text]	
79. SIGNATURE OF PROSECUTOR [Faint text]		80. SIGNATURE OF DEFENSE [Faint text]		81. SIGNATURE OF JURY [Faint text]	
82. SIGNATURE OF JUDGE [Faint text]		83. SIGNATURE OF PROSECUTOR [Faint text]		84. SIGNATURE OF DEFENSE [Faint text]	
85. SIGNATURE OF JURY [Faint text]		86. SIGNATURE OF JUDGE [Faint text]		87. SIGNATURE OF PROSECUTOR [Faint text]	
88. SIGNATURE OF DEFENSE [Faint text]		89. SIGNATURE OF JURY [Faint text]		90. SIGNATURE OF JUDGE [Faint text]	
91. SIGNATURE OF PROSECUTOR [Faint text]		92. SIGNATURE OF DEFENSE [Faint text]		93. SIGNATURE OF JURY [Faint text]	
94. SIGNATURE OF JUDGE [Faint text]		95. SIGNATURE OF PROSECUTOR [Faint text]		96. SIGNATURE OF DEFENSE [Faint text]	
97. SIGNATURE OF JURY [Faint text]		98. SIGNATURE OF JUDGE [Faint text]		99. SIGNATURE OF PROSECUTOR [Faint text]	
100. SIGNATURE OF DEFENSE [Faint text]		101. SIGNATURE OF JURY [Faint text]		102. SIGNATURE OF JUDGE [Faint text]	

1306 CERTIFICATE OF DEATH

01303

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland				c. LENGTH OF STAY IN 1b 8mo. 26 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Isiah First Gordy Last				4. DATE OF DEATH Month Jan Day 10 Year 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 17, 1888	
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 71 Days 10 Hours 19 Min.		11. IF UNDER 24 HRS. Hours 19 Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unk				10b. KIND OF BUSINESS OR INDUSTRY unk		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Westly Gordy				14. MOTHER'S MAIDEN NAME Nancy Gordy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk				16. SOCIAL SECURITY NO. unk		INFORMANT Address Hospital Records Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent Cerebral Thrombosis w/rt. Hemiplegy 332X DUE TO Arteriosclerosis general Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) ? DUE TO (c) ?							INTERVAL BETWEEN ONSET AND DEATH 5d.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of prostate gland							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Apr. 15, 1959 to Jan 10, 1960 , that I last saw the deceased alive on Jan 10, 1960 , and that death occurred at 7:40A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED Jan. 10, 1960							
ACTUAL SIGNATURE V. Juerman M.D.							
PHYSICIAN'S NAME (Type) V. Juerman, M.D. Salisbury, Maryland Jan. 10, 1960							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		1/16/1960		Glasseco Cemetery		Parsonsbury Md	
23. FUNERAL DIRECTOR'S SIGNATURE Clinton F. Stewart				ADDRESS Salisbury, Md.		24a. REC'D BY REGISTRAR DATE JAN 15 '60	
						24b. REGISTRAR'S SIGNATURE Clinton F. Stewart	

1306 CERTIFICATE OF DEATH

James William ...
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01304

1307

Item 9 - Film G254-1/15/60-mb

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Solihy</u>		c. LENGTH OF STAY IN 1b <u>7 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>upper Fairmont</u>		19x-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer Island State Hosp</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>L</u> Last <u>Hopkins</u>				4. DATE OF DEATH Month <u>1</u> Day <u>4</u> Year <u>1960</u>			
5. SEX <u>♀</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-31-1841</u>	9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months <u>78</u> Days <u>78</u>	IF UNDER 24 HRS. Hours <u>78</u> Min. <u>78</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Halland</u>				14. MOTHER'S MAIDEN NAME <u>Mary W. Craswell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mary Homer P. Arnold</u> Address <u>MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Paralytic Stroke</u> 904.7 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fracture Rt. hip.</u> (c) <u>Fracture Rt. hip.</u> DUE TO (c) <u>Fracture Rt. hip.</u> DUE TO cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe degenerative arteriosclerosis - hypercholesterolemia</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell to floor Deer Island Hosp.</u>					
20c. TIME OF INJURY Hour <u>8:45</u> a.m. <input checked="" type="checkbox"/> p.m. <input type="checkbox"/>	Month, Day, Year <u>1 3 60</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>	20f. (City or town) <u>Solihy</u>	(County) <u>Wicomico</u>	(State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Rager</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Rager</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>1-6-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fairmont Oak</u>		22d. LOCATION (City, town, or county) (State) <u>Fairmont MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin R. Wilson Prince</u>				ADDRESS <u>MD</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 11 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1308

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01305

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Quantico			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS Route # 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Jesse Middle Hull Last Hull				4. DATE OF DEATH Month 1-5-60 Day 19 Year 19				
5. SEX M		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 9-5-94		
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 65 Days 65		IF UNDER 24 HRS. Hours 65 Min. 65				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman			10b. KIND OF BUSINESS OR INDUSTRY Educational		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Hull				14. MOTHER'S MAIDEN NAME Irene Moore				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unknown		17. INFORMANT Mrs. Winefred Dutton R F D # 2 Quantico				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized peritonitis 550.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Ruptured appendix (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE Earl L. Royer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Earl L. Royer, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/> 1-9-60				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-9-60		22c. NAME OF CEMETERY OR CREMATORY Hull Cem.		22d. LOCATION (City, town, or county) (State) Wicomico, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Thornton B. Jolley, Salisbury Md.				24a. REC'D BY REGISTRAR JAN 15 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Fries		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1309 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 601 DeCatur		d. STREET ADDRESS 601 DeCatur	
3. NAME OF DECEASED (Type or print) First LUCY Middle Last HUMES		4. DATE OF DEATH Month JANUARY Day 22 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11, 1898
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 1 Days 11	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Mardela, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME James Graham	
14. MOTHER'S MAIDEN NAME Martha - - - -		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. INFORMANT		Mrs. Pauline Moore (Daughter) R.D.#3 Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular Accident 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 58 to August 59 that I last saw the deceased alive at August 59 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 226 N. Division St DATE SIGNED Jan. 25 / 1960 ACTUAL SIGNATURE Carrie Hearn M.D. PHYSICIAN'S NAME (Type) Dr. Carrie I. Hearn North Division St Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 28 / 1960	22c. NAME OF CEMETERY OR CREMATORY Spring Grove Cemetery	22d. LOCATION (City, town, or county) (State) R.D.# Mardela, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		24a. REC'D BY REGISTRAR DATE JAN 29 '60	24b. REGISTRAR'S SIGNATURE Carrie I. Hearn

1

Page 4

death.

VS A15 (4)

15M 9/58

TO HOSPITAL OR TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1982 - CERTIFICATE OF MAIL

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
[The remainder of the document contains several paragraphs of text that are extremely faint and largely illegible due to the quality of the scan. The text appears to be a standard memorandum format with a subject line, followed by several lines of body text.]

1310

CERTIFICATE OF DEATH

Reg. Dist. No.

01307

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin 23X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Sanitarium, Inc.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mrs. Maude Bounds Humphreys		4. DATE OF DEATH Month Day Year Jan. 2, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 22, 1883
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) BENNETT CO (MD)		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME EDWARD BOUNDS		14. MOTHER'S MAIDEN NAME EMILY PUGBY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT MISS MARY HUMPHREYS		Address BERLIN MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1 Cerebral Thrombosis, multiple 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Arteriosclerosis, Generalized (c) ?		INTERVAL BETWEEN ONSET AND DEATH 4 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 Bronchiectasis 2 Pneumonitis, recurrent.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/24 19 59 , to 1-2-60 , 19 60 , that I last saw the deceased alive on 1-2-60 , 19 60 , and that death occurred at 10:20 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Rufus S. Gardner, Jr.		ADDRESS (Street, city or town, state) DATE SIGNED Salisbury Blvd. and Pine Bluff Rd. Salisbury, Md.	
PHYSICIAN'S NAME (Type) Rufus S. Gardner, Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/5/59	22c. NAME OF CEMETERY OR CREMATORY BUCKINGHAM	22d. LOCATION (City, town, or county) (State) BERLIN MD.
23. FUNERAL DIRECTOR'S SIGNATURE Arthur P. Barbey		24a. REC'D BY REGISTRAR DATE JAN 7 '60	
ADDRESS Berlin Md		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11307

1310 CERTIFICATE OF DEATH

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

11307

1311 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 1 Wk			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron			
				f. STREET ADDRESS Rt # 1			
				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle ANNE Last INSCOE				4. DATE OF DEATH Month 1 Day 22 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 16, 1915	
				9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
				11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sr. Nurses Aid				10b. KIND OF BUSINESS OR INDUSTRY Hospital			
13. FATHER'S NAME Ruffin Collie				14. MOTHER'S MAIDEN NAME Mary Annie Powell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 243-20-3898		17. INFORMANT Address Mr. Curtis Inscoe, Hebron, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage (2) 330x DUE TO Severe hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 8 days Years.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/23/1960 to 1/22/1960 , that I last saw the deceased alive on 1/22/1960 , and that death occurred at 2:25 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 211 Maryland Ave. Salisbury, Md DATE SIGNED 1/25/60							
ACTUAL SIGNATURE O. J. Burton, M.D.				PHYSICIAN'S NAME (Type) O. J. Burton, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-24-60		22c. NAME OF CEMETERY OR CREMATORY Mardela Cemetery		22d. LOCATION (City, town, or county) (State) Mardela, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland				24a. REC'D BY REGISTRAR DATE JAN 27 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

Norman T. Baker

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH Jan 5, 1928		5. PLACE OF BIRTH Jackson, Mississippi	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5' 10"		10. WEIGHT 170	
11. CAUSE OF DEATH Suicide		12. MANNER OF DEATH Homicide		13. DATE OF DEATH Jan 24, 1968		14. PLACE OF DEATH Baltimore, Maryland		15. TIME OF DEATH 10:00 AM	
16. SIGNATURE OF DECEASED James Earl Ray		17. SIGNATURE OF WITNESS John Edgar Hoover		18. SIGNATURE OF PHYSICIAN John Edgar Hoover		19. SIGNATURE OF CORONER John Edgar Hoover		20. SIGNATURE OF JURY John Edgar Hoover	
21. SIGNATURE OF DECEASED James Earl Ray		22. SIGNATURE OF WITNESS John Edgar Hoover		23. SIGNATURE OF PHYSICIAN John Edgar Hoover		24. SIGNATURE OF CORONER John Edgar Hoover		25. SIGNATURE OF JURY John Edgar Hoover	
26. SIGNATURE OF DECEASED James Earl Ray		27. SIGNATURE OF WITNESS John Edgar Hoover		28. SIGNATURE OF PHYSICIAN John Edgar Hoover		29. SIGNATURE OF CORONER John Edgar Hoover		30. SIGNATURE OF JURY John Edgar Hoover	
31. SIGNATURE OF DECEASED James Earl Ray		32. SIGNATURE OF WITNESS John Edgar Hoover		33. SIGNATURE OF PHYSICIAN John Edgar Hoover		34. SIGNATURE OF CORONER John Edgar Hoover		35. SIGNATURE OF JURY John Edgar Hoover	
36. SIGNATURE OF DECEASED James Earl Ray		37. SIGNATURE OF WITNESS John Edgar Hoover		38. SIGNATURE OF PHYSICIAN John Edgar Hoover		39. SIGNATURE OF CORONER John Edgar Hoover		40. SIGNATURE OF JURY John Edgar Hoover	
41. SIGNATURE OF DECEASED James Earl Ray		42. SIGNATURE OF WITNESS John Edgar Hoover		43. SIGNATURE OF PHYSICIAN John Edgar Hoover		44. SIGNATURE OF CORONER John Edgar Hoover		45. SIGNATURE OF JURY John Edgar Hoover	
46. SIGNATURE OF DECEASED James Earl Ray		47. SIGNATURE OF WITNESS John Edgar Hoover		48. SIGNATURE OF PHYSICIAN John Edgar Hoover		49. SIGNATURE OF CORONER John Edgar Hoover		50. SIGNATURE OF JURY John Edgar Hoover	
51. SIGNATURE OF DECEASED James Earl Ray		52. SIGNATURE OF WITNESS John Edgar Hoover		53. SIGNATURE OF PHYSICIAN John Edgar Hoover		54. SIGNATURE OF CORONER John Edgar Hoover		55. SIGNATURE OF JURY John Edgar Hoover	
56. SIGNATURE OF DECEASED James Earl Ray		57. SIGNATURE OF WITNESS John Edgar Hoover		58. SIGNATURE OF PHYSICIAN John Edgar Hoover		59. SIGNATURE OF CORONER John Edgar Hoover		60. SIGNATURE OF JURY John Edgar Hoover	
61. SIGNATURE OF DECEASED James Earl Ray		62. SIGNATURE OF WITNESS John Edgar Hoover		63. SIGNATURE OF PHYSICIAN John Edgar Hoover		64. SIGNATURE OF CORONER John Edgar Hoover		65. SIGNATURE OF JURY John Edgar Hoover	
66. SIGNATURE OF DECEASED James Earl Ray		67. SIGNATURE OF WITNESS John Edgar Hoover		68. SIGNATURE OF PHYSICIAN John Edgar Hoover		69. SIGNATURE OF CORONER John Edgar Hoover		70. SIGNATURE OF JURY John Edgar Hoover	
71. SIGNATURE OF DECEASED James Earl Ray		72. SIGNATURE OF WITNESS John Edgar Hoover		73. SIGNATURE OF PHYSICIAN John Edgar Hoover		74. SIGNATURE OF CORONER John Edgar Hoover		75. SIGNATURE OF JURY John Edgar Hoover	
76. SIGNATURE OF DECEASED James Earl Ray		77. SIGNATURE OF WITNESS John Edgar Hoover		78. SIGNATURE OF PHYSICIAN John Edgar Hoover		79. SIGNATURE OF CORONER John Edgar Hoover		80. SIGNATURE OF JURY John Edgar Hoover	
81. SIGNATURE OF DECEASED James Earl Ray		82. SIGNATURE OF WITNESS John Edgar Hoover		83. SIGNATURE OF PHYSICIAN John Edgar Hoover		84. SIGNATURE OF CORONER John Edgar Hoover		85. SIGNATURE OF JURY John Edgar Hoover	
86. SIGNATURE OF DECEASED James Earl Ray		87. SIGNATURE OF WITNESS John Edgar Hoover		88. SIGNATURE OF PHYSICIAN John Edgar Hoover		89. SIGNATURE OF CORONER John Edgar Hoover		90. SIGNATURE OF JURY John Edgar Hoover	
91. SIGNATURE OF DECEASED James Earl Ray		92. SIGNATURE OF WITNESS John Edgar Hoover		93. SIGNATURE OF PHYSICIAN John Edgar Hoover		94. SIGNATURE OF CORONER John Edgar Hoover		95. SIGNATURE OF JURY John Edgar Hoover	
96. SIGNATURE OF DECEASED James Earl Ray		97. SIGNATURE OF WITNESS John Edgar Hoover		98. SIGNATURE OF PHYSICIAN John Edgar Hoover		99. SIGNATURE OF CORONER John Edgar Hoover		100. SIGNATURE OF JURY John Edgar Hoover	

FILED - JAN 24 1968

1. This certificate is to be filled out by the physician or coroner who has examined the body of the deceased and has determined the cause and manner of death. It is to be filed in the office of the State Department of Health, Baltimore, Maryland, and a copy is to be sent to the local health department and the county health officer. 2. The cause of death should be stated in as much detail as possible, and should include the immediate cause, the underlying cause, and any other significant conditions. 3. The manner of death should be stated as either natural, accidental, suicidal, or homicidal. 4. The date and place of death should be stated. 5. The signature of the physician or coroner should be written in ink. 6. The signature of the witness should be written in ink. 7. The signature of the physician should be written in ink. 8. The signature of the coroner should be written in ink. 9. The signature of the jury should be written in ink. 10. The signature of the deceased should be written in ink. 11. The signature of the witness should be written in ink. 12. The signature of the physician should be written in ink. 13. The signature of the coroner should be written in ink. 14. The signature of the jury should be written in ink. 15. The signature of the deceased should be written in ink. 16. The signature of the witness should be written in ink. 17. The signature of the physician should be written in ink. 18. The signature of the coroner should be written in ink. 19. The signature of the jury should be written in ink. 20. The signature of the deceased should be written in ink. 21. The signature of the witness should be written in ink. 22. The signature of the physician should be written in ink. 23. The signature of the coroner should be written in ink. 24. The signature of the jury should be written in ink. 25. The signature of the deceased should be written in ink. 26. The signature of the witness should be written in ink. 27. The signature of the physician should be written in ink. 28. The signature of the coroner should be written in ink. 29. The signature of the jury should be written in ink. 30. The signature of the deceased should be written in ink. 31. The signature of the witness should be written in ink. 32. The signature of the physician should be written in ink. 33. The signature of the coroner should be written in ink. 34. The signature of the jury should be written in ink. 35. The signature of the deceased should be written in ink. 36. The signature of the witness should be written in ink. 37. The signature of the physician should be written in ink. 38. The signature of the coroner should be written in ink. 39. The signature of the jury should be written in ink. 40. The signature of the deceased should be written in ink. 41. The signature of the witness should be written in ink. 42. The signature of the physician should be written in ink. 43. The signature of the coroner should be written in ink. 44. The signature of the jury should be written in ink. 45. The signature of the deceased should be written in ink. 46. The signature of the witness should be written in ink. 47. The signature of the physician should be written in ink. 48. The signature of the coroner should be written in ink. 49. The signature of the jury should be written in ink. 50. The signature of the deceased should be written in ink. 51. The signature of the witness should be written in ink. 52. The signature of the physician should be written in ink. 53. The signature of the coroner should be written in ink. 54. The signature of the jury should be written in ink. 55. The signature of the deceased should be written in ink. 56. The signature of the witness should be written in ink. 57. The signature of the physician should be written in ink. 58. The signature of the coroner should be written in ink. 59. The signature of the jury should be written in ink. 60. The signature of the deceased should be written in ink. 61. The signature of the witness should be written in ink. 62. The signature of the physician should be written in ink. 63. The signature of the coroner should be written in ink. 64. The signature of the jury should be written in ink. 65. The signature of the deceased should be written in ink. 66. The signature of the witness should be written in ink. 67. The signature of the physician should be written in ink. 68. The signature of the coroner should be written in ink. 69. The signature of the jury should be written in ink. 70. The signature of the deceased should be written in ink. 71. The signature of the witness should be written in ink. 72. The signature of the physician should be written in ink. 73. The signature of the coroner should be written in ink. 74. The signature of the jury should be written in ink. 75. The signature of the deceased should be written in ink. 76. The signature of the witness should be written in ink. 77. The signature of the physician should be written in ink. 78. The signature of the coroner should be written in ink. 79. The signature of the jury should be written in ink. 80. The signature of the deceased should be written in ink. 81. The signature of the witness should be written in ink. 82. The signature of the physician should be written in ink. 83. The signature of the coroner should be written in ink. 84. The signature of the jury should be written in ink. 85. The signature of the deceased should be written in ink. 86. The signature of the witness should be written in ink. 87. The signature of the physician should be written in ink. 88. The signature of the coroner should be written in ink. 89. The signature of the jury should be written in ink. 90. The signature of the deceased should be written in ink. 91. The signature of the witness should be written in ink. 92. The signature of the physician should be written in ink. 93. The signature of the coroner should be written in ink. 94. The signature of the jury should be written in ink. 95. The signature of the deceased should be written in ink. 96. The signature of the witness should be written in ink. 97. The signature of the physician should be written in ink. 98. The signature of the coroner should be written in ink. 99. The signature of the jury should be written in ink. 100. The signature of the deceased should be written in ink.

1312 CERTIFICATE OF DEATH

01309

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN lb <u>90 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Johnson</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>1</u> Day <u>24</u> Year <u>19 60</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-2-01</u>
9. AGE (In years lost birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months <u>58</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John White</u>	
14. MOTHER'S MAIDEN NAME <u>Annie Frisbee</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unk.</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>unk.</u>		17. INFORMANT <u>Deer's Head Records</u> Address <u>Salisbury, Md.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic congestion of lung</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Hypertensive arteriosclerotic cardiovascular disease, decompensated.</u> (c) <u>Arteriosclerosis, general</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> <u>Years</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Recurrent cerebral thrombosis and pyelonephritis, chronic.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>10-26</u> , 19 <u>59</u> to <u>1-24-</u> , 19 <u>60</u>
20f. (City or town) <u>Salisbury</u>		(County) <u>Salisbury</u> (State) <u>Md.</u>
21. I certify that I attended the deceased from <u>10-26</u> , 19 <u>59</u> to <u>1-24-</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-24</u> , 19 <u>60</u> , and that death occurred at <u>8:05</u> PM, from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>V. Juerman</u>		DATE SIGNED <u>1-25-60</u>
PHYSICIAN'S NAME (Type) <u>V. Juerman, M. D.</u>		ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u>
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/28/60</u>
22c. NAME OF CEMETERY OR CREMATORY <u>Still Pond (col) Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Still Pond, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Walker</u>		24a. REC'D BY REGISTRAR <u>DATE JAN 28 '60</u>
ADDRESS <u>Chestertown, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

1

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1313 CERTIFICATE OF DEATH

Reg. Dist. No.

01310

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>147 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u>		<u>09x-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>Box 130¹/₂, Rt. #2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lucy Johnson</u>				4. DATE OF DEATH Month Day Year <u>1 13 1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-25-1900</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>factories</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Henry</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Robins on</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unk.</u>		16. SOCIAL SECURITY NO. <u>unk.</u>		INFORMANT <u>Deer's Head Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. } (b) <u>Arteriosclerosis, general</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-19</u> , 19 <u>59</u> , to <u>1-13</u> , 19 <u>60</u> , that I lost s/he the deceased on <u>1-13</u> , 19 <u>60</u> , and that death occurred at <u>5:50a</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>V. Juerman</u> M.D.				ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u> DATE SIGNED <u>1-13-60</u>			
PHYSICIAN'S NAME (Type) <u>V. Juerman, M. D.</u>				LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>1-15-60</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Calto. Med. Sch.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE <u>FEB 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

80991

Page 4

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

01340

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

W. J. ...

1342

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01311

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharptown</u>		c. LENGTH OF STAY IN 1b <u>5 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X RURAL - SHARPTOWN MD</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SALLIE NMI Johnson</u>				4. DATE OF DEATH Month <u>1</u> Day <u>22</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 2-1890</u>		9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>PHILLIP SATCHEL</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>FAMBS JOHNSON, LAUREL, DELAWARE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute enteric colitis</u> <u>571.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (c), stating the underlying cause lost. DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic schistosomiasis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u></u> o. m. <u></u> p. m. <u></u>	Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Earl L. Royer</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<u>1-27-60</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/29/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CAREY'S CHURCH</u>		22d. LOCATION (City, town, or county) <u>MILLSBORO, DELAWARE</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul & Anita Minist</u>				ADDRESS <u>ST Sharptown MD</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 1 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fries</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1314 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>T.</u> Last <u>Kennard</u>		4. DATE OF DEATH Month <u>1</u> Day <u>12</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-1-90</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Various</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Kennard</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Houston</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-03-2986</u>	
17. INFORMANT <u>Deer's Head Records</u>		18. ADDRESS <u>Salisbury, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyperstatic congestion of lungs</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Recurrent cerebral thrombosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that attended the deceased from <u>7-18</u> , 19 <u>55</u> , to <u>1-12</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-12</u> , 19 <u>60</u> , and that death occurred at <u>5:50</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. V. Maldve, M.D.</u>		ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u> DATE SIGNED <u>1-13-60</u>	
PHYSICIAN'S NAME (Type) <u>L. V. Maldve, M.D.</u>		<u>Salisbury, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 16, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pomona (col) Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Nr. Chestertown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Genneth Waddy</u>		ADDRESS <u>Chestertown, Md.</u>	24a. REC'D BY REGISTRAR <u>JAN 18 '60</u> DATE
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

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Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

CERTIFICATE OF DEATH

1914

MASSACHUSETTS
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
OFFICE OF THE REGISTRAR
BOSTON

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Place of death: _____

8. Cause of death: _____

9. Signature of Registrar: _____

10. Signature of Physician: _____

11. Signature of Coroner: _____

12. Signature of Burial Officer: _____

13. Signature of Minister: _____

14. Signature of Undertaker: _____

15. Signature of Family: _____

16. Signature of Friends: _____

17. Signature of Neighbors: _____

18. Signature of Others: _____

19. Signature of Witnesses: _____

20. Signature of Clergy: _____

21. Signature of Others: _____

22. Signature of Others: _____

23. Signature of Others: _____

24. Signature of Others: _____

25. Signature of Others: _____

26. Signature of Others: _____

27. Signature of Others: _____

28. Signature of Others: _____

29. Signature of Others: _____

30. Signature of Others: _____

31. Signature of Others: _____

32. Signature of Others: _____

33. Signature of Others: _____

34. Signature of Others: _____

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99. Signature of Others: _____

100. Signature of Others: _____

1315 CERTIFICATE OF DEATH

Reg. Dist. No.

01313

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wicomico</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY, IN 1b <u>1 month</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Reynolds General Hospital</u>				d. STREET ADDRESS <u>23X-2</u>			
3. NAME OF DECEASED (Type or print) <u>Raymond M. Lewis</u> First <u>Raymond</u> Middle <u>M.</u> Last <u>Lewis</u>				4. DATE OF DEATH <u>January 30 1960</u> Month <u>January</u> Day <u>30</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 3 - 1888</u>	
9. AGE (In years last birthday) <u>71 3/4</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>		IF UNDER 24 HRS. Months <u>3</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Raymond</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Impounded Bay</u>			
11. BIRTHPLACE (State or foreign country) <u>Chambliss, Va.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Daniel Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Imbrey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-28-444</u>			
17. INFORMANT <u>Mrs. Ethel V. Lewis</u>				Address <u>Quail #1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Pyelonephritis, Right</u> DUE TO (c) <u>90 days</u>				INTERVAL BETWEEN ONSET AND DEATH <u>20 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>90 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1-2-60</u> , 19 <u>60</u> , to <u>1-30-60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 30th</u> , 19 <u>60</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Raymond M. You</u>				ADDRESS (Street, city or town, state) <u>707 Camden Ave Salisbury MD 1-31-60</u>			
PHYSICIAN'S NAME (Type) <u>Raymond M. You</u>				DATE SIGNED <u>1-31-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb 2/60</u>		<u>Baptist Cemetery</u>		<u>Salisbury md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Alley Kinnis</u>				ADDRESS <u>Snodgrass, Md</u>			
24a. REC'D BY REGISTRAR <u>FEB 2 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

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DATE

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1343 CERTIFICATE OF DEATH

Reg. Dist. No.

01314

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANTIONETTE Middle (NETTIE) Last LIVINGSTON		4. DATE OF DEATH Month JAN. Day 12th Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 20, 1876
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) R.D.# 1 Salisbury, Md		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Anthony George Brown		14. MOTHER'S MAIDEN NAME Mary Malone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Mr Lee R. Livingston (Husband) R.D.# 1 Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart FAILURE 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic coronary insufficiency (c) generalized atherosclerotic disease			INTERVAL BETWEEN ONSET AND DEATH 6 mrs. 10-15 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic malnutrition			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 20, 1959 , to January 12, 1960 , that I last saw the deceased alive on December 31, 1959 , and that death occurred at 6:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Fruitland, Maryland DATE SIGNED Jan. 12 /1960			
ACTUAL SIGNATURE Robert J. Adkins M.D.		DATE SIGNED Jan. 12 /1960	
PHYSICIAN'S NAME (Type) Dr. Robert Adkins Fruitland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 14, 1960	22c. NAME OF CEMETERY OR CREMATORY Union Cemetery - R.D.# Salisbury, Maryland	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		24a. REC'D BY REGISTRAR JAN 15 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

1

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or funeral home.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1863 CERTIFICATE OF DEATH

Location _____

Residence _____

W. A. D. D. _____

Age _____

Sex _____

Color _____

Religion _____

Married _____

Occupation _____

Education _____

Previous Illness _____

Cause of Death _____

Time of Death _____

Place of Death _____

Signature _____

Witness _____

Minister _____

Physician _____

Coroner _____

Registrar _____

Witness _____

Minister _____

1344 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Upper Bridge St		d. STREET ADDRESS Upper Bridge St	
3. NAME OF DECEASED (Type or print) CHARLES PATRICK MAC KENZIE		4. DATE OF DEATH Month JANUARY Day 25th Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1865
9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR 10 Months 8 Days 8 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Weaver- Retired Employee		10b. KIND OF BUSINESS OR INDUSTRY Ireland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Ralph MacKenzie		14. MOTHER'S MAIDEN NAME Mary Higgins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Mrs. Alice Maurry (Daughter) Bridge St Mardela, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 540.0 DUE TO Cerebral Hemorrhages Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 21 New Stomach (c) 54 years			INTERVAL BETWEEN ONSET AND DEATH 2 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/25 , 19 60 , to 1/25 , 19 60 , that I last saw the deceased alive on 1/25 , 19 60 , and that death occurred at 2:00 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE H.S. Kuhlman		ADDRESS (Street, city or town, state) Jan. 29/1960	
PHYSICIAN'S NAME (Type) Dr. H.S. Kuhlman		Sharptown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Feb. 1, 1960	Holy Sepulchre Cemetery-Philadelphia, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE HOLIOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR FEB 1 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kuntz	

1

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH



Place of death

Residence

Age

Sex

Color

Place of birth

Married

Occupation

Education

Religion

Service

Signature

Date

Time

Place

Signature

Date

Time

Place

Signature

Date

Time

CERTIFICATE OF DEATH

Reg. Dist. No.

01316

1316

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>			c. LENGTH OF STAY IN 1b <u>12</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>			e. d. STREET ADDRESS <u>Regency Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>MACMILLAN</u> Last <u>MACMILLAN</u>			4. DATE OF DEATH Month <u>JANUARY</u> Day <u>24</u> Year <u>1960</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 24, 1944</u>		9. AGE (In years last birthday) <u>15</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>ALFRED R. MAC MILLAN</u>			14. MOTHER'S MAIDEN NAME <u>OLGA FERNANDEZ</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		INFORMANT Address <u>ALFRED R. MACMILLAN Regency Dr. Salisbury, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Schiller's Disease</u> <u>355x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH 4 years</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-8</u> , 19 <u>60</u> , to <u>1-24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-24</u> , 19 <u>60</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>William A. Ellis Jr.</u>			ADDRESS (Street, city or town, state) DATE SIGNED <u>Salisbury, Md.</u> <u>1-24-60</u>		
PHYSICIAN'S NAME (Type) <u>William A. Ellis Jr.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/26/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Mem. Park</u>	
				22d. LOCATION (City, town, or county) (State) <u>SALISBURY Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas H. Wallace, Salisbury, Md.</u>			24a. REC'D BY REGISTRAR DATE <u>JAN 27 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Orlando S. Kinner</u>

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1918

RECEIVED

1918

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "RECEIVED" and "1918" are visible.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G256 2-19-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

01317

1317

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>STOCKTON, Md 238-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES A. MARSHALL</u>		4. DATE OF DEATH Month Day Year <u>JANUARY 24 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 8 1878</u>
9. AGE (In years last birthday) yrs. <u>81</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OYSTERMAN</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN MARSHALL</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
INFORMANT <u>Robert Marshall - Stockton, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis & Benign prostatic hypertrophy</u> DUE TO (c) <u>hypertrophy</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-9</u> , 19 <u>60</u> , to <u>1-24</u> , 19 <u>60</u> that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>1:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. F. J.</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>1-25-60</u>	
PHYSICIAN'S NAME (Type) <u>Edgar Wharton - Newchurch, Va.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-25-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FORMAN</u>		22d. LOCATION (City, town, or county) (State) <u>STOCKTON, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - Newchurch, Va.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 2 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kline</u>			

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1318 CERTIFICATE OF DEATH

Reg. Dist. No.

01318

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>STOCKTON, Md. 23x-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>OSCAR H. MASON</u>		4. DATE OF DEATH Month Day Year <u>JANUARY 29 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 12, 1915</u>
9. AGE (In years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FACTORY-WORK</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>SAMUEL MASON</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE BAINE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. ADDRESS <u>Laurelia T. Mason - Pocomoke, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JANUARY 28, 1960</u> to <u>JANUARY 29, 1960</u> , that I last saw the deceased alive on <u>JANUARY 29, 1960</u> , and that death occurred at <u>7 A. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Edgar W. Wharton</u> M.D. PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-2-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul</u>	22d. LOCATION (City, town, or county) (State) <u>Stockton, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar W. Wharton - New Church, Va.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 5 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon permits. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JOEL MIXTER

1917 DECEASED

1917

1319 CERTIFICATE OF DEATH

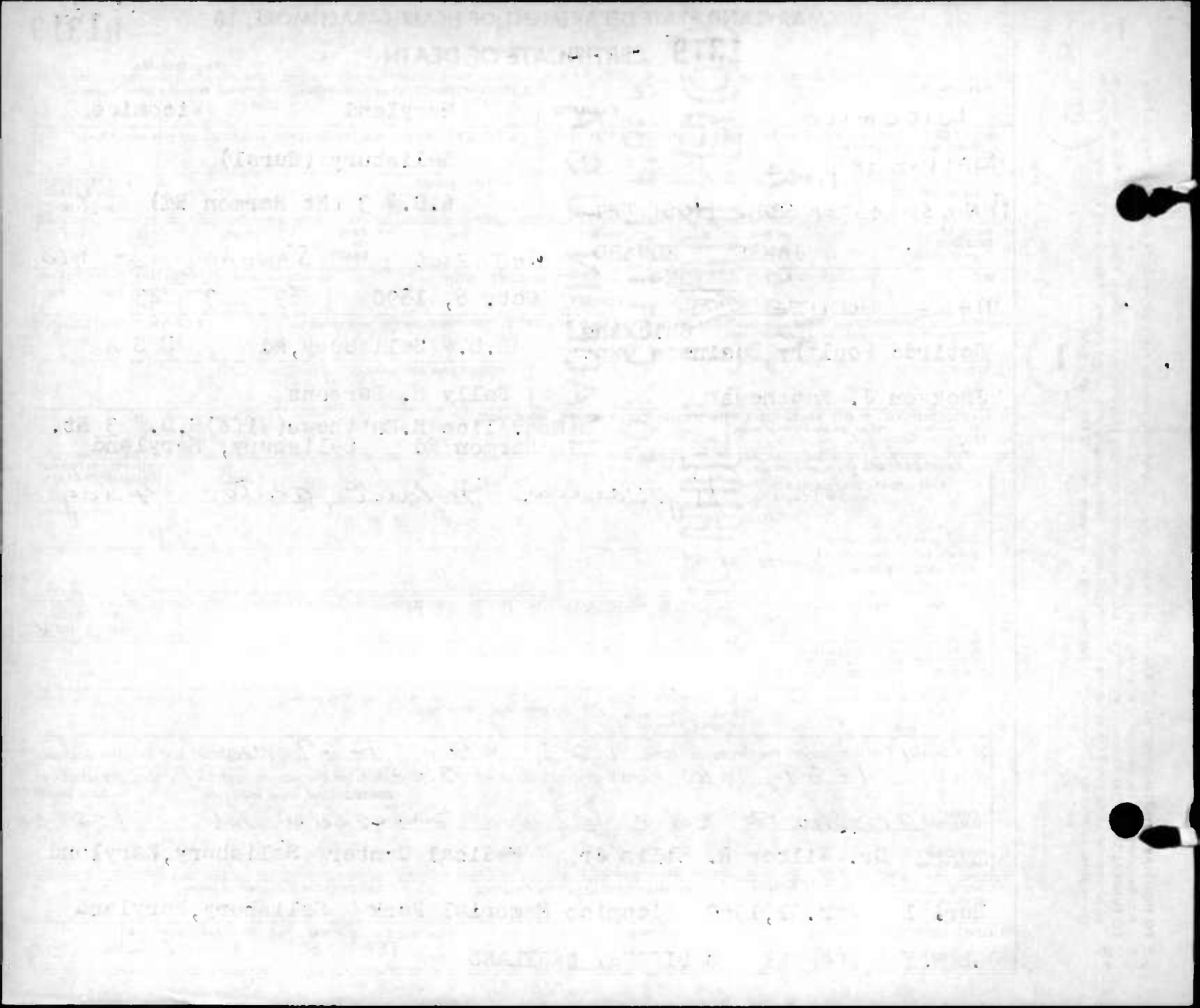
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>1 R.D.# 3 (Mt Hermon Rd)</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>EDWARD</u> Last <u>MATTHEWS</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 6, 1890</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>23</u>	IF UNDER 24 HRS. Hours <u>23</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Poultry Business Owner</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Chickens</u>		11. BIRTHPLACE (State or foreign country) <u>R.D.# Salisbury, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
13. FATHER'S NAME <u>Jackson J. Matthews</u>				14. MOTHER'S MAIDEN NAME <u>Sally M. Parsons</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Mrs. Alice M. Matthews (Wife) R.D.# 3 Mb. Hermon Rd Salisbury, Maryland</u>				
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-25</u> , 19 <u>60</u> , to <u>1-29</u> , 19 <u>60</u> that I last saw the deceased alive on <u>1-29</u> , 19 <u>60</u> , and that death occurred at <u>3:10 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>1-29-60</u>							
ACTUAL SIGNATURE <u>William R. Ellis Jr.</u>			M.D. <u>Salisbury, Md.</u>				
PHYSICIAN'S NAME (Type) <u>Dr. Wilber R. Ellis Jr</u>			Medical Center Salisbury, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 31, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>				ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 1 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01320

1320 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 13 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Walter Last Mears		4. DATE OF DEATH Month January Day 3 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-7-99
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 60 Days 60 Hours 60 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Farmer		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George R. Mears		14. MOTHER'S MAIDEN NAME Laura F. Watson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Deer's Head Records Address Mrs. Mary E. Mears (wife) 303 S. Park Dr. Salisbury, Maryland	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Right Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 163X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of transverse colon		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-21 , 19 59 , to 1-3 , 19 60 , that I last saw the deceased alive on 1-3 , 19 60 , and that death occurred at 10a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 1-4-60 ACTUAL SIGNATURE L. V. Maldve M.D. Deer's Head State Hospital PHYSICIAN'S NAME (Type) Leonid V. Maldve, M.D. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 6, 1960	
22c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY -SALISBURY MARYLAND		24a. REC'D BY REGISTRAR JAN 5 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

1930 CERTIFICATE OF DEATH

10-9-30

10-9-30

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CERTIFICATE OF DEATH

Reg. Dist. No.

01321

1321

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland				c. LENGTH OF STAY IN lb 10 MO.22 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First David Middle Earl Last Nesbitt				4. DATE OF DEATH Month Jan Day 31 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 16, 1894	9. AGE (In years last birthday) yrs. 65	IF UNDER 1 YEAR Months 65	IF UNDER 24 HRS. Days 65 Hours 65 Min. 65	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY unk		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles T. Nesbitt				14. MOTHER'S MAIDEN NAME Ida E. Winchester			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. unk		INFORMANT Hospital Records		Address Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Arteriosclerotic generalized Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH -- years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/9/59 , 19 59 , to 1/31 , 19 60 , that I last saw the deceased alive on Jan 31 , 19 60 , and that death occurred at 12:40P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 1/31/60							
ACTUAL SIGNATURE L. Maldve		M.D. Salisbury, Maryland					
PHYSICIAN'S NAME (Type) L. Maldve, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-3-60		22c. NAME OF CEMETERY OR CREMATORY Hopewell Methodist Cem.		22d. LOCATION (City, town, or county) (State) Rising Sun, R.D. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph P. Grant		ADDRESS North East Md		24a. REC'D BY REGISTRAR DATE FEB 4 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film G255 1/27/60 1wk

Reg. Dist. No.

01322

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Accomac	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chincoteague 83x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 307 Church St.	
3. NAME OF DECEASED (Type or print) First Olivia Middle E Last Northam		4. DATE OF DEATH Month 1 Day 4 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1883
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Northam		14. MOTHER'S MAIDEN NAME Elizabeth Northam	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Elizabeth Foxwell, Chincoteague, Va.	
17. INFORMANT Elizabeth Foxwell, Chincoteague, Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Encephalomalacia DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH days weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture Rt. Hip		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home	
20c. TIME OF INJURY Month, Day, Year 11 15 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Chincoteague Accomac Va	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Earl L. Royer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 7, 1960	
22c. NAME OF CEMETERY OR CREMATORY Downing Cemetery		22d. LOCATION (City, town, or county) (State) Oak Hall, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Selzer		ADDRESS Chincoteague, Va.	
24a. REC'D BY REGISTRAR JAN 20 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kears	

1323 CERTIFICATE OF DEATH

Reg. Dist. No.

01323

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> XXXXXXXXXX <u>Parsonsbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>		d. STREET ADDRESS <u>Box 1135 (Salisbury)</u>	
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>JOHN</u> Last <u>Oswald</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>16</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12, 1901</u>
9. AGE (In years lost birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinest - Employee - Fish Products</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brooklyn N.Y.</u>	
11. BIRTHPLACE (State or foreign country) <u>U S A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Harry Oswald</u>		14. MOTHER'S MAIDEN NAME <u>Addie Volland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>W.W.#</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. ADDRESS <u>Mrs. Esther Oswald (Wife) Parsonsbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary Artery Heart Disease</u> DUE TO <u>Coronary Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumatic Heart Disease (Mitral Stenosis)</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1/16/60</u> to <u>1/16/60</u> , that I last saw the deceased alive on <u>1/16/60</u> , and that death occurred at <u>5:18 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Gilmore</u>		ADDRESS (Street, city or town, state) <u>Salisbury Md.</u> DATE SIGNED <u>1/16/60</u>	
PHYSICIAN'S NAME (Type) <u>David J. Gilmore</u>		<u>Medical Center Salisbury, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 19, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Springhill Memory Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>R.D.# Salisbury, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
24a. REC'D BY REGISTRAR <u>JAN 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. H. H. H.</u>	

1

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1324 CERTIFICATE OF DEATH

Reg. Dist. No. 01324

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 109 W. Vine St		d. STREET ADDRESS 109 W. Vine St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BERTIE Middle ELLEN Last PARSONS		4. DATE OF DEATH Month JANUARY Day 29th Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1875
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 84 Days 84 Hours 84 Min.	IF UNDER 24 HRS. Months 84 Days 84 Hours 84 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Wicomico Co. Maryland
12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Dewitt J. Pryor		14. MOTHER'S MAIDEN NAME Josephine Staton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Mr. Milton Parsons (Son) Address 109 W. Vine St Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sensitivity DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/2/58 , 19 60 , to 1/30/60 , that I last saw the deceased alive on 1/29/60 , 19 60 , and that death occurred at 11:30 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED Feb. 2/1/1960	
ACTUAL SIGNATURE Dr. Andrew C. Mitchell		M.D. Salisbury, Md.	
PHYSICIAN'S NAME (Type) Dr. O. J. Burton		Maryland Ave Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 1, 1960	
22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR DATE FEB 3 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAXIMUM THERMAL STABILITY OF HEALTH
1938
THE UNIVERSITY OF MICHIGAN
ANN ARBOR, MICHIGAN
DEPARTMENT OF CHEMISTRY
FACULTY OF SCIENCE
DIVISION OF CHEMISTRY
LABORATORY OF PHYSICAL CHEMISTRY
P.O. BOX 220
ANN ARBOR, MICHIGAN 48106
U.S.A.

1325 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 310 Ellegood St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NORA Middle LEAH Last PARSONS		4. DATE OF DEATH Month JANUARY Day 30th Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1874 July 5, 1884
9. AGE (In years last birthday) yrs. 85		IF UNDER 1 YEAR Months 8 Days 25 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work at Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Shad Point (Wico. Co.) Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William McGrath		14. MOTHER'S MAIDEN NAME Elizabeth Stewart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. INFORMANT Mrs. Esther P. Hillman (Daughter) Address 310 Ellegood St Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis. 443x DUE TO atherosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Essential Hypertension (c) Coronary artery thrombosis. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dehydration.			INTERVAL BETWEEN ONSET AND DEATH 2 weeks Years Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____ to 1/30/1960 , that I last saw the deceased alive on 1/29/1960 , and that death occurred at 3:45 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) January 1/1960 DATE SIGNED			
ACTUAL SIGNATURE [Signature] M.D.		DATE SIGNED January 1/1960	
PHYSICIAN'S NAME (Type) Dr. O. J. Burton		Maryland Ave. Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 2, 1960	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		24a. REC'D BY REGISTRAR FEB 2 '60	
ADDRESS SALISBURY MARYLAND		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/58

1386

STATE OF NEW YORK
IN SENATE
JANUARY 1, 1901
REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
MAY 1, 1899
ALBANY: J. B. LIPPINCOTT & CO. PRINTERS.
1901.

CERTIFICATE OF DEATH

01326

1326

Item 8 Film 255 2-8-60 et

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN lb 12 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Private Sanitarium 1022 Riverside Drive		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 1022 Riverside Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM ELISHA PARSONS		4. DATE OF DEATH Month Day Year JANUARY 27th 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1899
9. AGE (In years last birthday) yrs. 70		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Auto Mechanic-Garage	
11. BIRTHPLACE (State or foreign country) R.D.#Salisbury, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Benjamin Parsons		14. MOTHER'S MAIDEN NAME Melissia Savage	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. INFORMANT Mrs Grace B. Parsons (Wife) 1022 Riverside Drive Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Arteriosclerotic Cardiovascular Disease (c) ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Skeletal Metastases, Severe			INTERVAL BETWEEN ONSET AND DEATH 22 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/23 , 19 59 , to 1/27 , 19 60 , that I last saw the deceased alive on 1/20 , 19 60 , and that death occurred at 259 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Rufus S. Gardner Jr M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Jan. 29 / 1960	
PHYSICIAN'S NAME (Type) Dr. Rufus S. Gardner		Pine Bluff Road Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 29, 1960	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR DATE FEB 1 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARY AND STATE OF MARYLAND - BOSTON, MASS.

CERTIFICATE OF DEATH

1938

County of Prince George's, State of Maryland

On the 10th day of May, 1938

at the City of Washington, D.C.

I, the undersigned, a duly qualified physician, do hereby certify that

the within and foregoing is a true and correct copy of the

original as the same appears in the records of the Registrar of the

Department of Health, State of Maryland.

Witness my hand and seal this 10th day of May, 1938.

Attest: My hand and seal this 10th day of May, 1938.

Registrar of the Department of Health, State of Maryland.

My hand and seal this 10th day of May, 1938.

Attest: My hand and seal this 10th day of May, 1938.

Registrar of the Department of Health, State of Maryland.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1345

CERTIFICATE OF DEATH

Reg. Dist. No.

01327

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.F.D. 2 Quantico</u>				c. LENGTH OF STAY IN 1b <u>X</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home R.F.D. 2 Quantico Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Paulette</u> Middle <u>R.</u> Last <u>Price</u>				4. DATE OF DEATH Month <u>January</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 22, 1959</u>	
9. AGE (In years last birthday) <u>7</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>3</u> Hours <u>19</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Levin Turner</u>				14. MOTHER'S MAIDEN NAME <u>Helen Price</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>Helen Price, R.F.D. 2 Quantico Md</u>			
17. INFORMANT <u>Helen Price</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>525X Interstitial Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>4 day</u> DUE TO (c) <u>INTERSTITIAL PNEUMONIA</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 day</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>2 Jan</u> , 19 <u>60</u> to <u>5 Jan</u> , 19 <u>60</u> that I last saw the deceased alive on <u>5 Jan</u> , 19 <u>60</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. H. Purnell</u>				ADDRESS (Street, city or town, state) <u>657 M. Main St. S. Md.</u>			
DATE SIGNED <u>Jan 5, 1960</u>							
PHYSICIAN'S NAME (Type) <u>E. H. PURNELL, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>Jan. 5, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Quantico Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart, Salisbury Md</u>				ADDRESS <u>2082 234 XV4</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 7 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
16. SIGNATURE OF CLERK		17. SIGNATURE OF CHURCH		18. SIGNATURE OF FUNERAL HOME		19. SIGNATURE OF BURIAL PLACE		20. SIGNATURE OF CREMATOR	
21. SIGNATURE OF CORONER		22. SIGNATURE OF JURY		23. SIGNATURE OF COURT		24. SIGNATURE OF STATE		25. SIGNATURE OF FEDERAL	
26. SIGNATURE OF LOCAL		27. SIGNATURE OF DISTRICT		28. SIGNATURE OF COUNTY		29. SIGNATURE OF STATE		30. SIGNATURE OF FEDERAL	
31. SIGNATURE OF LOCAL		32. SIGNATURE OF DISTRICT		33. SIGNATURE OF COUNTY		34. SIGNATURE OF STATE		35. SIGNATURE OF FEDERAL	
36. SIGNATURE OF LOCAL		37. SIGNATURE OF DISTRICT		38. SIGNATURE OF COUNTY		39. SIGNATURE OF STATE		40. SIGNATURE OF FEDERAL	
41. SIGNATURE OF LOCAL		42. SIGNATURE OF DISTRICT		43. SIGNATURE OF COUNTY		44. SIGNATURE OF STATE		45. SIGNATURE OF FEDERAL	
46. SIGNATURE OF LOCAL		47. SIGNATURE OF DISTRICT		48. SIGNATURE OF COUNTY		49. SIGNATURE OF STATE		50. SIGNATURE OF FEDERAL	
51. SIGNATURE OF LOCAL		52. SIGNATURE OF DISTRICT		53. SIGNATURE OF COUNTY		54. SIGNATURE OF STATE		55. SIGNATURE OF FEDERAL	
56. SIGNATURE OF LOCAL		57. SIGNATURE OF DISTRICT		58. SIGNATURE OF COUNTY		59. SIGNATURE OF STATE		60. SIGNATURE OF FEDERAL	
61. SIGNATURE OF LOCAL		62. SIGNATURE OF DISTRICT		63. SIGNATURE OF COUNTY		64. SIGNATURE OF STATE		65. SIGNATURE OF FEDERAL	
66. SIGNATURE OF LOCAL		67. SIGNATURE OF DISTRICT		68. SIGNATURE OF COUNTY		69. SIGNATURE OF STATE		70. SIGNATURE OF FEDERAL	
71. SIGNATURE OF LOCAL		72. SIGNATURE OF DISTRICT		73. SIGNATURE OF COUNTY		74. SIGNATURE OF STATE		75. SIGNATURE OF FEDERAL	
76. SIGNATURE OF LOCAL		77. SIGNATURE OF DISTRICT		78. SIGNATURE OF COUNTY		79. SIGNATURE OF STATE		80. SIGNATURE OF FEDERAL	
81. SIGNATURE OF LOCAL		82. SIGNATURE OF DISTRICT		83. SIGNATURE OF COUNTY		84. SIGNATURE OF STATE		85. SIGNATURE OF FEDERAL	
86. SIGNATURE OF LOCAL		87. SIGNATURE OF DISTRICT		88. SIGNATURE OF COUNTY		89. SIGNATURE OF STATE		90. SIGNATURE OF FEDERAL	
91. SIGNATURE OF LOCAL		92. SIGNATURE OF DISTRICT		93. SIGNATURE OF COUNTY		94. SIGNATURE OF STATE		95. SIGNATURE OF FEDERAL	
96. SIGNATURE OF LOCAL		97. SIGNATURE OF DISTRICT		98. SIGNATURE OF COUNTY		99. SIGNATURE OF STATE		100. SIGNATURE OF FEDERAL	

1327 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 564 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Arthur Middle Roberts Last Roberts				4. DATE OF DEATH Month January Day 29 Year 1960			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/26/1900	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 59 Days 59 Hours 59 Min.		IF UNDER 24 HRS. Months 59 Days 59 Hours 59 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.				16. SOCIAL SECURITY NO. ?			
INFORMANT Deer's Head State Hospital Address Records							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, general DUE TO (c) ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ? INTERVAL BETWEEN ONSET AND DEATH 4 days Years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 15 , 19 58 , to Jan. 29 , 19 60 , that I last saw the deceased alive on January 29 , 19 60 , and that death occurred at 11:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 1/30/60 ACTUAL SIGNATURE L. V. Maldve M.D. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D. Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF 2-4-60							
22c. NAME OF CEMETERY OR CREMATORY Lockwood							
22d. LOCATION (City, town, or county) (State) Salisbury, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE Barber M. Deet							
24a. REC'D BY REGISTRAR DATE FEB 9 '60							
24b. REGISTRAR'S SIGNATURE Arthur L. Hines							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1328 CERTIFICATE OF DEATH

Reg. Dist. No.

01329

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>15 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>none</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thurman Savage</u>		4. DATE OF DEATH Month Day Year <u>1 22 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6-19-11</u>
9. AGE (In years lost birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>W.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>?</u>	
INFORMANT <u>EA Thurmon Savage Jr.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unresolved pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 15, 1960</u> , to <u>Jan 22, 1960</u> that I last saw the deceased alive on <u>Jan 7, 1960</u> and that death occurred at <u>104</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L.V. Sohler</u>		ADDRESS (Street, city or town, state) <u>302 East St. Annapolis</u> DATE SIGNED <u>1-25-60</u>	
PHYSICIAN'S NAME (Type) <u>L.V. Sohler</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-30-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Stokton Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Stokton Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Barker McWest</u> ADDRESS		24a. REC'D BY REGISTRAR <u>JAN 27 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

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Page 4

24 hours with. Page 4

THE HOSPITAL OR PHYSICIAN: The law requires that the death certificate be executed within 24 hours with. Page 4

TO HOSPITAL OR PHYSICIAN: The law requires that the death certificate be executed within 24 hours with. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1329 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>27 Days</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>M.</u> Last <u>Shackley</u>			4. DATE OF DEATH Month <u>January</u> Day <u>10</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 16 - 1902</u>	9. AGE (In years last birthday) <u>57 yrs</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u> Hours <u>24</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>City Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Snow Hill, md</u>		11. BIRTHPLACE (State or foreign country) <u>Windsor, md</u>	
13. FATHER'S NAME <u>Edward M. Shackley</u>			14. MOTHER'S MAIDEN NAME <u>Linna Mae Riggins</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-03-8463</u>		INFORMANT <u>Ms Julia H. Shackley, Snow Hill, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Lymphocytic Leukemia</u> 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>Dec 14</u> , 19 <u>59</u> , to <u>Jan 10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 4</u> , 19 <u>60</u> , and that death occurred at <u>9 AM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Pine Bluff Road Salisbury, md</u>		DATE SIGNED <u>1/10/60</u>	
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, county)	(State)	
<u>Burial Jan 13/60</u>		<u>Windsor Cemetery</u>	<u>Snow Hill</u>	<u>md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne E. Ginn</u>		ADDRESS <u>Snow Hill, md</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 13 1960</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1958

MASSACHUSETTS
BUREAU OF VITAL RECORDS
DEPARTMENT OF HEALTH



1346 CERTIFICATE OF DEATH

Reg. Dist. No.

01331

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 40 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD # 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gertrude Middle Margaret Last Shockley		4. DATE OF DEATH Month Jan. Day 21 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-17-1909
9. AGE (In years lost birthday) 50 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Salisbury, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DeWitt Rounds		14. MOTHER'S MAIDEN NAME Laura Bridell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
INFORMANT Jas. George Shockley, Salisbury, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral vascular accident 331X DUE TO (b) hypertension, essential, severe, 10 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 5 min			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1954 to Jan 21, 1960 , that I last saw the deceased alive on October 29, 1959 , and that death occurred at 8:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 303 East 8th, Delmar Md. DATE SIGNED Jan 23, 60			
ACTUAL SIGNATURE L.V. Sohler M.D.		PHYSICIAN'S NAME (Type) L.V. Sohler	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-25-60	
22c. NAME OF CEMETERY OR CREMATORY M.E.		22d. LOCATION (City, town, or county) (State) Delmar, Del.	
23. FUNERAL DIRECTOR'S SIGNATURE W. S. Marvel Co. Delmar, Del. ADDRESS		24a. REC'D BY REGISTRAR JAN 25 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of this certificate is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

1346 CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S-CERTIFICATE OF DEATH

01332

Reg. Dist. No.

1330

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carey Ave				d. STREET ADDRESS Carey Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGARET Middle ELIZABETH Last SHORT				4. DATE OF DEATH Month JANUARY Day 2nd Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 9, 1871		9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months 9 Days 22
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY Retired-None		11. BIRTHPLACE (State or foreign country) Sussex Co. Delaware		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Levin Esham				14. MOTHER'S MAIDEN NAME Mahala Hall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Henry Phillips (Daughter) Address Carey Ave. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C.V. Disease DUE TO (c) year							INTERVAL BETWEEN ONSET AND DEATH year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Earl L. Royer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. Earl L. Royer				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 5, 1960		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR JAN 6 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER - CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 15, 1920		Boston, Mass.	
Cause of Death		Disease		Injury		Poison		Other	
Heart Disease		Pneumonia		Falls		Alcohol		None	
Time of Death		Place of Death		Occupation		Marital Status		Religion	
10:30 AM		Home		Teacher		Married		Catholic	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Witness	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

1331 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Queens Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>69x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HETTIE</u> Middle <u>ISABELLA</u> Last <u>Sizemore</u>		4. DATE OF DEATH Month <u>January</u> Day <u>6</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 15, 1876</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Oxford North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Robert Elliott</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Rebecca Hunt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. ADDRESS <u>Mrs. Lillian Lloyd (Daughter) 143-11 84th Road Jamaica 35, New York</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>1 week</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-31, 1959</u> to <u>1-6, 1960</u> , that I last saw the deceased alive on <u>1-6, 1960</u> , and that death occurred at <u>9:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. Allen R. Ellis</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md. 1-6-60</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Dr. Wilber R. Ellis</u>		<u>Medical Center Salisbury, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 11 /60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Maple Grove Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Queens "Q" Gardens N.Y.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR <u>JAN 11 '60</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1133

1931 CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

NAME: [illegible] SEX: [illegible] AGE: [illegible] DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible] OCCUPATION: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

SIGNATURE OF REGISTRAR: [illegible]

DATE: [illegible]

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HILARY NELSON SMITH		4. DATE OF DEATH Month Day Year 1-23-60 19	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1924
9. AGE (In years last birthday) 35 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 11 21	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sander-Employee of Chris-Craft Corp		10b. KIND OF BUSINESS OR INDUSTRY R.D.# Salisbury, Md	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Wilmer J. Smith		14. MOTHER'S MAIDEN NAME Agnes Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mr. Raymond J. Smith (Brother) Lakeview Dr. Salisbury, Maryland	
17. INFORMANT Mr. Raymond J. Smith (Brother) Lakeview Dr. Salisbury, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Chest DUE TO 816X Conditions, if any, which gave rise to immediate cause (b) 816X (c), stating the underlying cause lost. DUE TO 816X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car involved in a collision.	
20c. TIME OF INJURY Month, Day, Year Hour P.M. 7 P.M. 1-14-60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Pine Bluff Rd. Salisbury Wicomico Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 26/1960	
22c. NAME OF CEMETERY OR CREMATORY St John's Cemetery		22d. LOCATION (City, town, or county) (State) Fruitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND		24a. REC'D BY REGISTRAR JAN 29 '60	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1333

CERTIFICATE OF DEATH

Reg. Dist. No.

01335

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 2 Hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				d. STREET ADDRESS 12 Salisbury 314 Park Ave.,			
3. NAME OF DECEASED (Type or print) First Middle Last LOUIS FRANCIS STEVENS				4. DATE OF DEATH Month Day Year 1 28 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 26, 1896		9. AGE (In years last birthday) yrs. 63	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager				10b. KIND OF BUSINESS OR INDUSTRY Bowling Alley		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Albert J. Stevens				14. MOTHER'S MAIDEN NAME Rebecca Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.I 213-12-5287		17. INFORMANT Mrs. L.F. Stevens, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Angina DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 4 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 58 to 1-28 , 19 60 , that I last saw the deceased alive on 1-28 , 19 60 , and that death occurred at 5:15 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 1-28-60							
ACTUAL SIGNATURE Andrew C. Mitchell M.D.				PHYSICIAN'S NAME (Type) Dr. A.C. Mitchell 211 Maryland Ave., Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-30-1960		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. S ADDRESS lisbury Maryland				24a. REC'D BY REGISTRAR DATE FEB 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

Norman T. Baker

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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1336 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>54 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>306 MARYLAND</u>				d. STREET ADDRESS <u>306 MARYLAND Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>HOBLITZELL</u> Last <u>TAYLOR</u>				4. DATE OF DEATH Month <u>1</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 20, 1870</u>	9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jeremiah Hoblitzell</u>				14. MOTHER'S MAIDEN NAME <u>Julia Daugherty</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Jamestaylor, Same</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <u>1955</u> to <u>Jan 3, 1960</u> , that I last saw the deceased alive on <u>Jan 2, 1959</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>226 N. Division St., Salisbury, Md</u> DATE SIGNED <u>Jan 4/59</u>							
ACTUAL SIGNATURE <u>Carrie Hearn</u> M.D. <u>226 N. Division St., Salisbury, Md</u>							
PHYSICIAN'S NAME (Type) <u>Dr. Carrie F. Hearn</u> <u>226 N. Division St., Salisbury, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1-5-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, MARYLAND</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury, Maryland</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>JAN 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hearn</u>	

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first step in the process of identifying a problem is to recognize that a problem exists. This is often done by comparing current performance with a desired state or goal. If there is a significant difference, a problem is identified.

2. The second step is to define the problem. This involves identifying the specific aspects of the problem that need to be addressed. It is important to be clear and concise in the definition of the problem.

3. The third step is to analyze the problem. This involves identifying the causes of the problem and the factors that contribute to it. This step is often the most difficult, as it requires a deep understanding of the system and the ability to identify the underlying causes.

4. The fourth step is to develop a solution. This involves identifying the actions that need to be taken to address the problem. It is important to consider the feasibility of the solution and the potential impact on the system.

5. The fifth step is to implement the solution. This involves putting the solution into practice and monitoring the results. It is important to be flexible and willing to make adjustments as needed.

6. The sixth step is to evaluate the results. This involves comparing the current performance with the desired state and determining whether the problem has been solved. If not, the process may need to be repeated.

7. The seventh step is to document the process. This involves recording the steps taken to identify and solve the problem. This can be useful for future reference and for sharing the knowledge with others.

8. The eighth step is to communicate the results. This involves sharing the findings of the process with the relevant stakeholders. This can help to build trust and ensure that everyone is on the same page.

9. The ninth step is to review the process. This involves reflecting on the process and identifying areas for improvement. This can help to ensure that the process is effective and efficient.

10. The tenth step is to continue to monitor the system. This involves keeping an eye on the system to ensure that the problem does not recur. This can help to maintain the stability of the system.

CERTIFICATE OF DEATH

Reg. Dist. No.

01337

1335

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury (Rural)</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>			e. STREET ADDRESS <u>R.D.# 1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Nicholas</u> Middle <u>Theodore</u> Last <u>Theodore</u>			4. DATE OF DEATH Month <u>January</u> Day <u>27</u> Year <u>1960</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20, 1885</u>	9. AGE (In years lost birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Bulgaria</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>					
13. FATHER'S NAME <u>No Record</u>			14. MOTHER'S MAIDEN NAME <u>No Record</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>Mr. Ota J. Stevenson (Friend) Meadow Bridge Rd. Salisbury, Maryland</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 CORONARY Thrombosis</u> DUE TO (b) <u>ARTERIO SCLEROTIC Heart disease</u> DUE TO (c) <u>generalized arteriosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>December</u> , 19 <u>59</u> , to <u>January 27</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>January 27</u> , 19 <u>60</u> , and that death occurred at <u>5:00 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Robert T. Adkins</u>		M.D. <u>FRUITLAND, MARYLAND</u> 27 Jan. 60			
PHYSICIAN'S NAME (Type) <u>Dr. Robert Adkins</u>		Fruitland Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 30, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Mem Park</u>	
22d. LOCATION (City, town, or county) <u>Salisbury, Maryland</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 1 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>					

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

05-25-95 15:21:22

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01338

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury, Md.</u>		LENGTH OF STAY (in this place) <u>since 12/28/59</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Maryland</u>				STREET ADDRESS (If rural give location) <u>RFD #3</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Murray Eugene Walston</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 11 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 14, 1914</u>	9. AGE last birthday <u>45</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Murray C. Walston</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Farlow</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-12-1395</u>		17. INFORMANT'S ADDRESS <u>Mrs. N. Elizabeth Walston (Wife) City Records of Pine Bluff State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
1. IMMEDIATE CAUSE (A) <u>434.4</u> <u>Cor. Pulmonale</u>						<u>4 wks.</u>	
2. ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>002 X Pulmonary Tuberculosis</u>						<u>3 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 28</u> , 19 <u>59</u> , to <u>Jan. 10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan. 10</u> , 19 <u>60</u> , and that death occurred at <u>2:53a</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Edward P. Ritchey</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Maryland</u>		DATE SIGNED <u>Jan. 11, 1960</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 13/60</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>JAN 15 '60</u>		REGISTRAR'S SIGNATURE <u>Charles S. Kinsler</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY-SALISBURY, MARYLAND</u>			

CERTIFICATE OF DEATH

Reg. Dist. No.

01339

1337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>5 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		d. STREET ADDRESS <u>Truitt #1</u> <u>23X2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lenora</u> Middle <u>M.</u> Last <u>Ward</u>				4. DATE OF DEATH Month <u>January</u> Day <u>14</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 22 - 1890</u>	9. AGE (In years last birthday) <u>69 14/25</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Castille Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Mears</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>207-16-9431</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Bronchitis and Pneumonia</u> <u>502.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Fibrosis and Emphysema</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 10</u> , 19 <u>60</u> , to <u>Jan. 14</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan. 14</u> , 19 <u>60</u> , and that death occurred at <u>4:45 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas C. Hill</u> M.D.				ADDRESS (Street, city or town, state) <u>Pine Bluff Road</u> DATE SIGNED <u>1/15/60</u>			
PHYSICIAN'S NAME (Type) <u>Salisbury Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Jan. 17/60</u>		22b. DATE THEREOF <u>Jan. 17/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Catoctin</u>		22d. LOCATION (City, town or county) (State) <u>Snow Hill Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Thomas</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1937



1341

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Allegheny ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 400 Pine Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Wilhemia Middle Minnie H. Last Weinert				4. DATE OF DEATH Month Jan. Day 11 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar 2, 1886	
9. AGE (In years lost birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Pittsburgh		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Pittsburgh	
13. FATHER'S NAME Charles Weisner				14. MOTHER'S MAIDEN NAME Elizabeth Keil			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		INFORMANT Mary Mullin, Delmar, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial infarct, posterior. DUE TO (c) Coronary artery atherosclerosis							INTERVAL BETWEEN ONSET AND DEATH 5 min. 3 days !
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Pittsburgh, Pa.				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 1/11 , 19 60 , to death , 19 60 , that I last saw the deceased alive on Jan 11 , 19 60 , and that death occurred at 10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Ernest M. Larnor M.D.				ADDRESS (Street, city or town, state) Delmar, Del			
PHYSICIAN'S NAME (Type) Ernest M. Larnor				DATE SIGNED 1/12/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-15-60		22c. NAME OF CEMETERY OR CREMATORY United		22d. LOCATION (City, town, or county) (State) Pittsburgh, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE W. S. Marvel Co - Delmar, Del				24a. REC'D BY REGISTRAR DATE JAN 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

11334

STATE OF CALIFORNIA - DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1941

Alameda

Alameda

San Jose

8 days

John

500 Line Street

3824 Hayes Street

John

William H.

William H.

Jan. 22

Mar. 2, 1941

John

Home

Home

Alameda

Alameda

Home

Home

John

John

John

John

John

John

John

John

John

John

John

John

1338

CERTIFICATE OF DEATH

Reg. Dist. No.

01341

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> 23X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hosp.</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Baby</u> First Middle Last		4. DATE OF DEATH <u>January 11</u> 19 <u>60</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 11, 1960</u>
9. AGE (In years last birthday) <u>759.3</u> yrs.		10. IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>1</u> Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury, md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Raymond L. Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Edna Wharton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u> INFORMANT <u>Raymond L. Jackson</u> Address <u>Snow Hill, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital anomalies - multiple</u> DUE TO (b) <u>759.3</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4:00 P-1-11, 1960</u> , to <u>5:30 P-1-11, 1960</u> , that I last saw the deceased alive on <u>1-11-</u> , 19 <u>60</u> , and that death occurred at <u>5:30 A</u> PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Stedman W. Smith</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Stedman W. Smith</u>		<u>Salisbury, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Jan. 15/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Goodspring Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton Dennis</u> ADDRESS <u>Snow Hill, Md</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 13 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>

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TO HOSPITAL OR FUNERAL HOME: This certificate must be completed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be attached with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

2082192XV4

1333 CERTIFICATE OF DEATH



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **01342**

1339

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General</u>				d. STREET ADDRESS <u>RFD</u>			
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Wilson</u> Last <u>Wilson</u>				4. DATE OF DEATH Month <u>1</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>30 Sept 1900</u>		9. AGE (In years last birthday) <u>59</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Saw Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>			
13. FATHER'S NAME <u>George Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Hettie Wilson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Hettie Wilson, Quantico, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>900.0 Broncho pneumonia</u> DUE TO (b) <u>Fractured ribs & hemothorax</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>6 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) <u>Fell down steps, slipped on ice</u>					
20c. TIME OF INJURY Hour <u>7:30</u> a. m. <input checked="" type="checkbox"/> p. m. <input type="checkbox"/> Month, Day, Year <u>1 15 1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
20f. (City or town) <u>Quantico</u>		(County) <u>Wicomico</u>		(State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Rayer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Rayer</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>1-26-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/31/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hd. of Creek Cem.</u>			
22d. LOCATION (City, town, or county) <u>Quantico, Md.</u>		(State) <u>Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 1 '60</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. Messing, Bivolve, Mt.</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur E. King</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01343

1347

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin RFD</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>/</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Wilson</u> Last <u>Wilson</u>				4. DATE OF DEATH Month <u>1</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-15-85</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Tyaskin</u>		12. CITIZEN OF WHAT COUNTRY? <u>Native</u>	
13. FATHER'S NAME <u>Benjamin Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Octavia Wilson, Tyaskin RFD, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arterio-Sclerotic Heart Dis.</u> (c) <u>4 years</u> DUE TO (a) stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/23/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>White Haven Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Tyaskin Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. J. [Signature]</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 22 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

MEDICAL CERTIFICATION

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any data is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		TIME OF DEATH	
JAMES H. HARRIS		45		M		W		JAN 15 1918		10:30 AM	
RESIDENCE		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS	
1000 N. E. ST.		HOME		HEART DISEASE		SUICIDE		CORONARY ARTERY DISEASE		PAIN IN CHEST	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE		PREVIOUS ILLNESS		TREATMENT	
CLOCK REPAIRER		HIGH SCHOOL		METHODIST		MARRIED		NONE		NONE	
SIGNED		WITNESSED		CORONER		JURY		FINDINGS		REMARKS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE		TIME		PLACE		CAUSE		MANNER		DISEASE	
JAN 15 1918		10:30 AM		HOME		HEART DISEASE		SUICIDE		CORONARY ARTERY DISEASE	
SIGNED		WITNESSED		CORONER		JURY		FINDINGS		REMARKS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE		TIME		PLACE		CAUSE		MANNER		DISEASE	
JAN 15 1918		10:30 AM		HOME		HEART DISEASE		SUICIDE		CORONARY ARTERY DISEASE	

1000 N. E. ST.
JAN 15 1918

1340

CERTIFICATE OF DEATH

Reg. Dist. No.

01344

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>24 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ISAAC Thomas Wimbrow</u>		4. DATE OF DEATH Month Day Year <u>January 25-1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 11, 1876</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Dairyman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Wimbrow</u>		14. MOTHER'S MAIDEN NAME <u>Letitia Cooper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic Cardiovascular Disease</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>25 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town) (County) (State)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1, 1960</u> , to <u>Jan 25, 1960</u> , that I last saw the deceased alive on <u>Jan 25, 1960</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D.		DATE SIGNED <u>1/25/60</u>	
PHYSICIAN'S NAME (Type) <u>Thomas C. Hill, Jr.</u>		<u>Salisbury, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-28-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hebron Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hebron, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co</u> ADDRESS <u>Salisbury, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	
24a. REC'D BY REGISTRAR <u>JAN 27 '60</u>		DATE	

01344

CENTRAL AVE OF DEATH

WADSWORTH